HEARING HEALTH CENTERS | NELSON HEARING AID SERVICE | FAIRMONT HEARING AID SERVICE | WORTHINGTON HEARING AID SERVICE

AUTHORIZATION TO RELEASE RECORDS

Today's Date: _____

Name: _____ DOB: ____/____/____
First Middle Last

Phone: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please disclose my medical health information to:

Unless otherwise stipulated, the medical record information is to include only **the complete hearing health history and all audiology records during the time period:**

From: _____ To: _____

I give permission to release only the information that I have selected to the individual or agency I have named. I understand that this release is valid up to one year from the date that I sign it and I may refuse to sign this authorization or revoke this authorization at any time in writing to that effect. I have given my consent freely, voluntarily, and without coercion. **I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.**

_____ _____
Signature of Patient / Parent / Legal Representative Date Signed

Expiration Date: _____ (one year from date signed)

By definition "Medical Records" could include:

1. Confidential HIV-related information (as defined in A.R.S. Section 36-661)
2. Confidential communicable disease-related information (as defined in A.R.S. Section 36-661)
3. Confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SEQ)
4. Confidential mental health diagnosis/treatment information

As stated above, we have only released audiological related medical records.

_____ _____
Signature of Healthcare rep. transmitting records Date Signed